

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01170

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY Talbot Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe, Md.		b. COUNTY Maryland	
c. LENGTH OF STAY IN 1b 23 Years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Trappe, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hans	First	Middle	Last
4. DATE OF DEATH 1	Month	Day	Year 30 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/1883
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME Marie Jensen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Le Compte Funeral Service, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. MYOCARDIAL INFARCTION			
(b) DUE TO CORONARY OCCLUSION		2 min.	
(c) ARTERIOSCLEROSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 30, 1960 to JAN. 30, 1960 , that I last saw the deceased alive on JAN. 30, 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald F. Bartley		ADDRESS (Street, city or town, state) 9 N. HANSON ST.	
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D.		DATE SIGNED 1-30-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/60	
22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park.		22d. LOCATION (City, town, or county) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE FEB 4 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL
may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

C. T.

J. V.

THURSDAY, APRIL 11, 1968

80

1968

DECEASED PERSON
NAME
ADDRESS
CITY, STATE, ZIP CODEDECEASED PERSON
NAME
ADDRESS
CITY, STATE, ZIP CODE

120

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MICHAELS		c. LENGTH OF STAY IN 1b 2-Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIO VISTA NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	
3. NAME OF DECEASED (Type or print) IDA		First M.	Middle BADGER
4. DATE OF DEATH Dec. 31-1872		Last 87	Month JAN
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1872-12-31		9. AGE (In years last birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) New York State		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Thompson		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 420.1		16. SOCIAL SECURITY NO. 17. INFORMANT Donald R. Curry	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) atherosclerotic coronary artery d			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) malnutrition - co-kepia - severe		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-20 , 19 60 to 1-30 , 19 65 , that I last saw the deceased alive on 1-30 , 19 60 , and that death occurred at 88 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1-30-60			
ACTUAL SIGNATURE May M. Reeser		DATE SIGNED 1-30-60	
PHYSICIAN'S NAME (Type) May M. Reeser		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-60	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE James Bros		ADDRESS 1661 1/2 Hope St.	
24a. REC'D BY REGISTRAR DATE FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

Signature

Title

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1171 CERTIFICATE OF DEATH

Reg. Dist. No.

01172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MR. DAVID	Middle J.	Last BALL
4. DATE OF DEATH	Month JAN	Day 30	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 21, 1874
9. AGE (In years last birthday) 85 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN	11. KIND OF BUSINESS OR INDUSTRY SEAFOOD	12. BIRTHPLACE (State or foreign country) NEAVITT, MD.
13. FATHER'S NAME DAWSON BALL	14. MOTHER'S MAIDEN NAME ISABELLE Hunt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. — ?	17. INFORMANT MRS. MARY C. BALL, NEAVITT, MD.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 20 Jan , 19 60 to 30 Jan , 19 60 , that I last saw the deceased alive on 30 Jan , 19 60 , and that death occurred at 130 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Lane Wroth	ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md 21660		DATE SIGNED 1-31-60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-60	22c. NAME OF CEMETERY OR CREMATORIAL Nearby Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Hamilton Harrison, St. Michaels		ADDRESS 110 E. Main St., St. Michaels, Md 21660	24a. REC'D BY REGISTRAR DATE FEB 3 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Tracy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1172 CERTIFICATE OF DEATH

Reg. Dist. No.

01173

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
Talbot MARYLAND		Maryland Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN lb 150g	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 EASTON	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1 Port St.	
3. NAME OF DECEASED (Type or print)		First	Middle
George			Brown
4. DATE OF DEATH		Month	Day
JAN 15		Year	1960
5. SEX M		6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH Dec. 4, 1904	
9. AGE (In years lost birthday) 55 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sovier		10b. KIND OF BUSINESS OR INDUSTRY Factory (Food)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Brown		14. MOTHER'S MAIDEN NAME Ellen Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		INFORMANT Mrs. Hattie Roberts, Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral edema of anphoxus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:55 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE E.C.H. Schmidt M.D.		DATE SIGNED 219 S. Washington St. 16, Jersey	
PHYSICIAN'S NAME (Type) E.C.H. Schmidt		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 1/18/60		22c. NAME OF CEMETERY OR CEMETORY Drappe Cemetery	
22d. LOCATION (City, town, or county) Md.		22d. LOCATION (City, town, or county) Drappe Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James D. Dorkill Easton, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Cecilia L. Thomas	

STATE OF KANSAS

STATE OF KANSAS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01174

Reg. Dist. No.

1173 CERTIFICATE OF DEATH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eastern</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Wilbert</i>	Middle <i>Brown, JR.</i>	4. DATE OF DEATH <i>January 30 1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 30, 1909</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland-Albdt. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William H. Griffin</i>		14. MOTHER'S MAIDEN NAME <i>Helen Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Helen Brown, Wye Mills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>492x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>9:50P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		ADDRESS (Street, city or town, state) <i>219 S Washington St. #660</i>	
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		DATE SIGNED <i>16 Mar 1960</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/1/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Sundown Cemetery</i>		22d. LOCATION (City, town, or county) <i>Gillaboro</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Dashiel, Eastern Md.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 8 '60</i>	
ADDRESS <i>2080182XVS</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1174 CERTIFICATE OF DEATH

Reg. Dist. No.

01175

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 42 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. STREET ADDRESS 719 D ST. N.E. Apt 202		d. STREET ADDRESS 47x-3	
3. NAME OF DECEASED (Type or print) James R. Bryan		4. DATE OF DEATH Jan 13 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1905	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
10. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William A. Bryan	
14. MOTHER'S MAIDEN NAME Elizabeth Baynard		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Helen Bryan, wife - son	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arteriosclerotic heart disease		Unknown	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 1960 (State)	
21. I certify that I attended the deceased from Jan 11, 1960 , to Jan 13, 1960 , that I last saw the deceased alive on 19 , and that death occurred at 2:22 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Robert W. Trevor		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/60	
22c. NAME OF CEMETERY OR CREMATORIUM Oxford Cemetery		22d. LOCATION (City, town or county) Oxford Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE JAN 19 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Film G255 2-5-60 et

01176

CERTIFICATE OF DEATH

Reg. Dist. No.

1175

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
Talbot		a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Talbot			
EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. STREET ADDRESS			
6 da		X Bellevue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Memorial Hospital		e. YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elliott	Middle M	Last Campbell		
4. DATE OF DEATH	Month JAN	Day 28	Year 1960		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-25-94 1960/12/25/1960		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Medical doctor		Virginia	U.S.		
13. FATHER'S NAME	14. MOTHER'S MARRIED NAME				
Elliott M. Campbell	BARTONIA D. Way				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT	Address		
Yes	W 44 1	Mrs. Samuel King	Alexandria, Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
332X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.					
(b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____ and that death occurred at 8:15 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE	Elliott Schmidt			M.D. 219 S Washington St., 20202, Maryland	1960
PHYSICIAN'S NAME (Type)	E.C.H. Schmidt			Fector 16, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)		
Burial	Jan. 29, 1960	Oreard Cemetery	Oxford, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
Maurice F. Deverman	Easton, Md.	DATED 1 '60	S. C. E.		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1176 CERTIFICATE OF DEATH

Reg. Dist. No.

01177

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>17 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>		d. STREET ADDRESS <i>611 South St.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Clara</i>	Middle <i></i>	Last <i>Dean</i>	4. DATE OF DEATH	Month <i>January</i>	Day <i>1</i>	Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 26, 1894</i>	9. AGE (In years last birthday) <i>65 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>John Breeding</i>		14. MOTHER'S MAIDEN NAME <i>Anna Starkey</i>		Address <i>Mrs. A.J. Starkey, Jr. Easton, Md.</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>350x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Infected Dentist Nurse</i> <i>Parkinson's Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>months</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>L. J. Eglseder</i>		M.D.		ADDRESS (Street, city or town, state) <i>12 N. Hanson</i>		DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>JAN. 4, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Easton, Maryland</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice F. Newham & Son</i>		ADDRESS <i>Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 7 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>				

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01178

1177 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>9 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>		d. STREET ADDRESS <i>1 Queen Anne Hotel</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Harvey</i>	Middle <i>P.</i>	Last <i>Elliott</i>	4. DATE OF DEATH <i>January</i>	Month <i>/</i>	Day <i>/</i>	Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 24 1889</i>	9. AGE (In years last birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SAME</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Thomas Elliott</i>			14. MOTHER'S MAIDEN NAME <i>Lottie Abbott</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>212-16-1499</i>		17. INFORMANT <i>Mrs. Hazel Stavell</i>		Address <i>Oxford Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>141.9</i>		DUE TO <i>Malnutrition</i>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>Carcinoma of tongue</i>						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>219 S. Washington St</i>	(County) <i>Worcester</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 3:08 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 7, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Oxford Cemetery</i>		22d. LOCATION (City, town, or county) <i>Oxford Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey E. Harvey & Son</i>		ADDRESS <i>Easton Md.</i>		24a. REC'D BY REGISTRAR DATE JAN 5 '60		24b. REGISTRAR'S SIGNATURE <i>Charles E. Thomas</i>		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

1950

5-25

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1178 CERTIFICATE OF DEATH

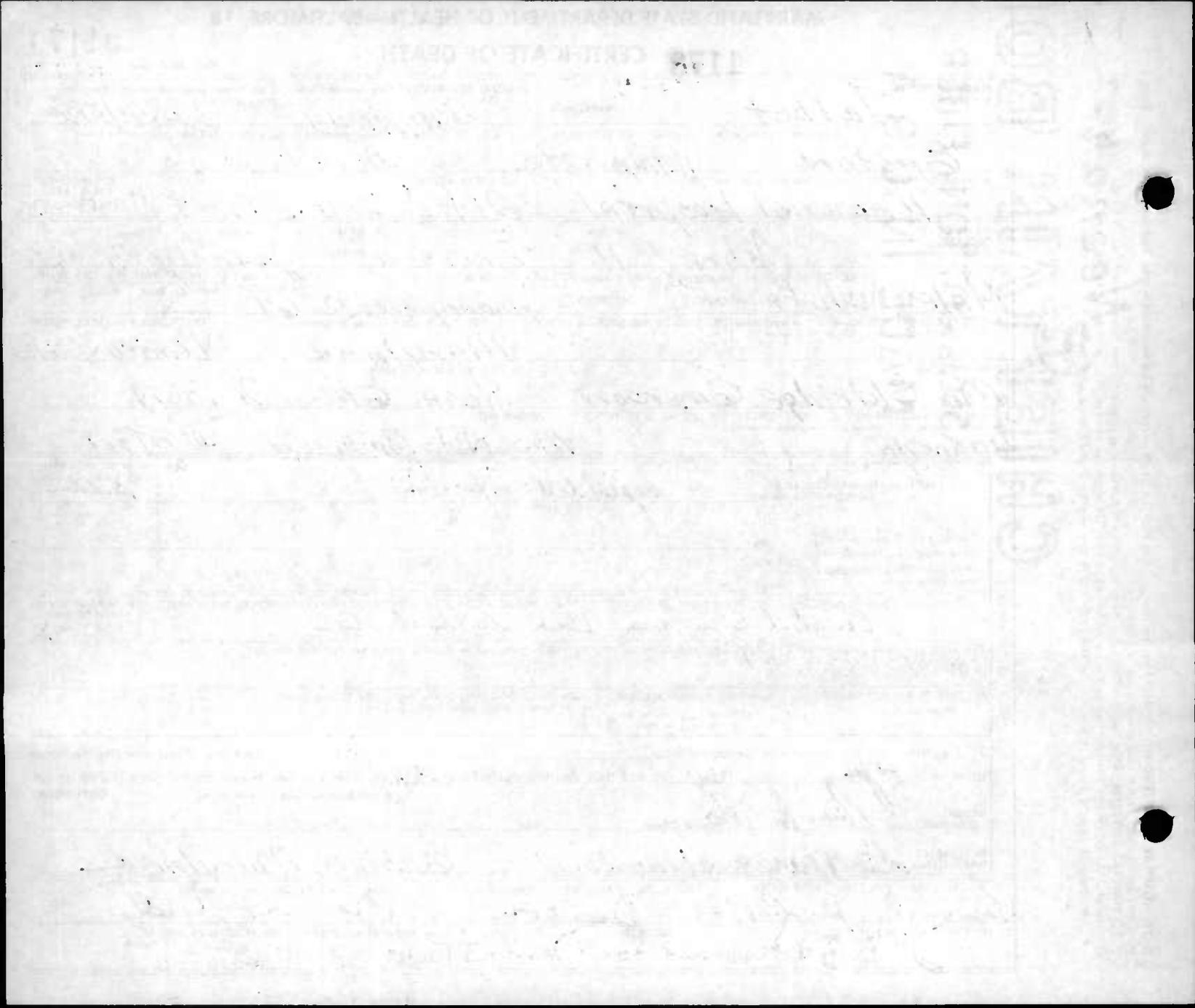
Reg. Dist. No.

01179

TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Jalbot		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Easton		11 days - 12 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Memorial Hospital		214 S. 2nd Street	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
John H. Emerson		January 21 1960	
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years at birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Mr. Eldridge Emerson		14. MOTHER'S M AIDEN NAME Rosa Ellen Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Nits Emerson - Denton.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Hyperkidal infection	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO	
{		{	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Essential hypertension, Chronic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Dr. Thurston Harrison		M.D.	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Jan 22 1960	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Denton		Denton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
D. L. Ferguson for Denton		24a. REC'D BY REGISTRAR DATE JAN 22 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

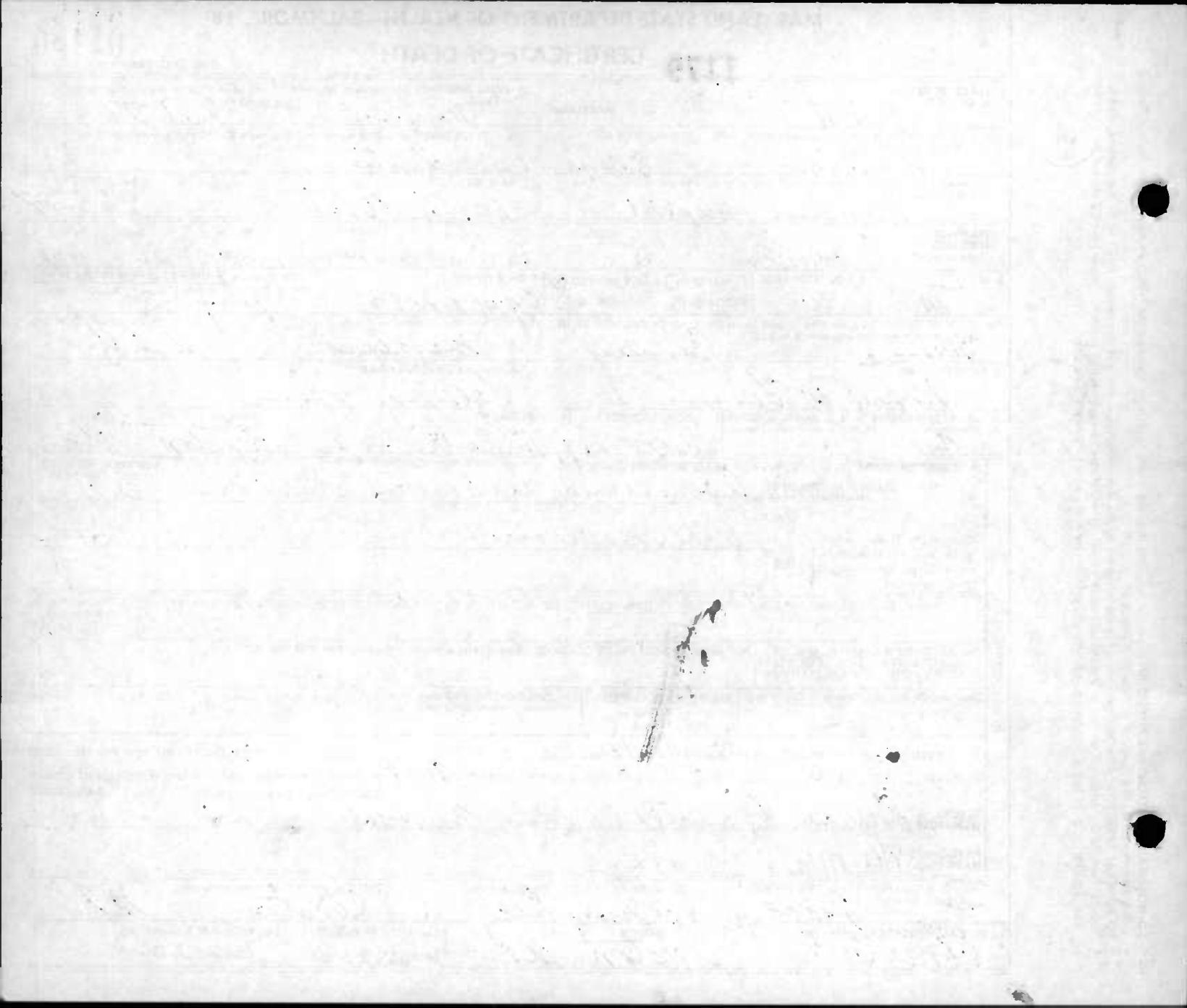
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1179 CERTIFICATE OF DEATH

Reg. Dist. No.

01180

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Talbot		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Talbot	
Easton.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
8 days		40 Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Memorial Hospital			
3. NAME OF DECEASED (Type or print)		First	Middle
William		J	Ewing
4. DATE OF DEATH		Month	Day
January 26		Year	1960
5. SEX		6. COLOR OR RACE	
M.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
W.		8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
77 yrs.		11. IF UNDER 24 HRS.	
Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Mechanic		11. BIRTHPLACE (State or foreign country)	
Cannery		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U.S.A.		Robert W. Ewing	
14. MOTHER'S MASTEN NAME		Catherine Henry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17.0-51247-8	
17. INFORMANT		Address	
Clark Ewing		Easton Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		3 weeks	
Arteriosclerotic Heart Disease c Heart Block.			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		1 year	
(b)		Arteriosclerosis.	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1959</u> to <u>1-26-60</u> that I last saw the deceased alive on <u>1-26-60</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
William L. Winters		M.D. Easton Md	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
William L. Winters		1-26-60	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Springfield Steel		Easton Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE	
		DATE JAN 29 '60	



TO HOSPITAL
may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01181

1180 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>26 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 EASTON</u>	
d. STREET ADDRESS <u>1278 HARRISON ST</u>		d. STREET ADDRESS <u>FAIRBANK</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha</u>		First <u>B</u>	Middle <u>I</u>
4. DATE OF DEATH <u>JAN 8 1960</u>		Lost	Month Day Year
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30 1875</u>
9. AGE (In years last birthday) <u>84 yrs.</u>		10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles R. Leonard</u>		14. MOTHER'S MARRIED NAME <u>Ida Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>586X</u>		16. SOCIAL SECURITY NO. <u>111-11-1111</u>	
17. INFORMANT <u>Mrs John Lambdin</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO <u>(2) Perihritis due to a ruptured gall bladder</u>		4-5 days.	
DUE TO <u>(3) Chronic ch. hepatitis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Easton</u> (County) <u>Wicomico</u> (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>Jan 8 1960</u> to <u>Jan 8 1960</u> , that I last saw the deceased alive on <u>Jan 8 1960</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Theresa Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>1/15/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Springfield</u>		22d. LOCATION (City, town, or county) <u>Easton</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice F. Neumann</u>		ADDRESS <u>521 E. Main St., Easton, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal; and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01182

1199

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXFORD		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) TRED AVON RIVER		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXFORD	
d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN WESLEY FORREST		First JOHN	Middle WESLEY
3. NAME OF DECEASED (Type or print) JOHN WESLEY FORREST		4. DATE OF DEATH FORREST	Month JAN
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1905
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1905
9. AGE (In years last birthday) 54	10. IF UNDER 1 YEAR Months 54	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ernest B. Forrest		14. MOTHER'S MAIDEN NAME Anna Eileen Pasquith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-14-2776	17. INFORMANT Address Mr. Benjamin Forrest Oxford, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH IMMED.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) FOUND FLOARING FACE-UP IN TRED AVON RIVER		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) V. SUP. HISTORY OF PALLOR AND MALAISE	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Lewis Welty</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WELTY		DATE SIGNED 1-19-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 21, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Oxford Cemetery	22d. LOCATION (City, town, or county) (State) Oxford, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Maryland	24a. REC'D BY REGISTRAR DATE 25/60
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

HT21231130 130227T000000Z 00000000
HT21231130 000000Z 210311T000000Z 130328Z

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2:45 AM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1181 CERTIFICATE OF DEATH

Reg. Dist. No. 01183

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boston</i>		c. LENGTH OF STAY IN 1b <i>7 Days - 12 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boston</i>		d. STREET ADDRESS <i>519 Lincoln Street</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. STREET ADDRESS <i>701 Main</i>		d. STREET ADDRESS <i>Boston</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ernest Hale Colored</i>		First <i>Ernest</i>	Middle <i>-</i>	Last <i>Gordy</i>	4. DATE OF DEATH <i>January 6, 1960</i>	Month <i>January</i>	Day <i>6</i>	Year <i>1960</i>	
5. SEX <i>Male Colored</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 24, 1904</i>	9. AGE (In years lost birthday) yrs. <i>52</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Talbot (Day)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
13. FATHER'S NAME <i>John Gordy</i>		14. MOTHER'S MAIDEN NAME <i>Hester Maria</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>47-11111</i>		17. INFORMANT <i>Patient's Chart (Summary sheet)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>199.2</i>		DUE TO <i>Electrolyte Imbalance</i>		DUE TO <i>Coronary disease with asides</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>None</i>		(b)		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>			
21. I certify that I attended the deceased from <i>December 30, 1959</i> , to <i>January 6, 1960</i> , that I last saw the deceased alive on <i>December 30, 1959</i> , and that death occurred at <i>2:45 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>		DATE SIGNED <i>1/6/60</i>			
ACTUAL SIGNATURE <i>J. B. Ambler</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Dr. J. B. Ambler, M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1/8/60</i>		22b. DATE THEREOF <i>1/8/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>U. of Md. Med. School</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>	(State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Moore & Son</i>		ADDRESS <i>Boston, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 12 '60</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. Thomas</i>				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1182 CERTIFICATE OF DEATH

Reg. Dist. No. 01184

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>110 W. 2nd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Francis R. Graves</i>	First	Middle	Last
4. DATE OF DEATH <i>1-4</i>	Month	Day	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 18, 1893</i>
9. AGE (In years lost birthday) <i>66 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		Address	
13. FATHER'S NAME <i>Lewis M. Graves</i>		14. MOTHER'S MAIDEN NAME <i>Lillian A. Tucker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Advanced bilateral pulmonary tuberculosis</i>	
DUE TO <i>002X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>> 2 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) DUE TO <i>Unknown</i>			
DUE TO <i>Unknown</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>202 Dover St.</i>	
(County)		(State)	
21. I certify that I attended the deceased from <i>12-29</i> , 19 <i>59</i> , to <i>1-3</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1-3</i> , 19 <i>60</i> , and that death occurred at <i>240</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Easton, Md.</i>	
ACTUAL SIGNATURE <i>Robert W. Trevor</i>		DATE SIGNED <i>1-3-60</i>	
PHYSICIAN'S NAME (Type) <i>Robert W. Trevor</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/6/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>GREEN LAWN CEM.</i>		22d. LOCATION (City, town, or county) <i>CAMBRIDGE MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert W. Trevor</i>		24e. REC'D BY REGISTRAR DATE <i>JAN 11 '60</i>	
ADDRESS <i>202 Dover St. Easton, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	

TO HOSPITAL
may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1100 CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

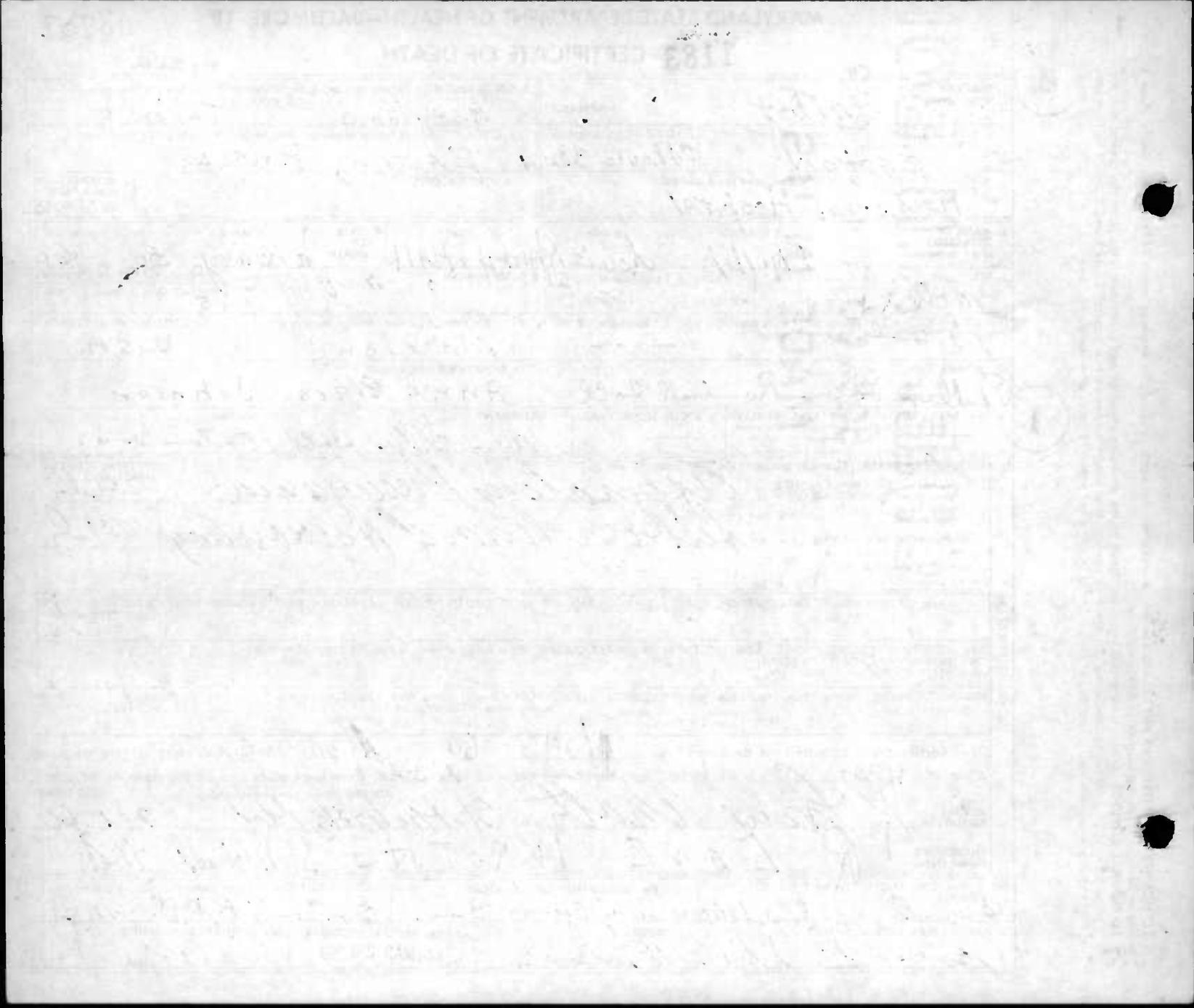
1183 CERTIFICATE OF DEATH 103787

Reg. Dist. No.

TO HOSPITAL and **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
J Talbot MARYLAND		a. STATE MARYLAND b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EASTON		c. LENGTH OF STAY IN 1b 24 hours - 33 yrs. X EASTON, RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Phillip Louis Randall Hall January 30 1960	
5. SEX Male		6. COLOR OR RACE Col	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH ?	
9. WIDOWED <input type="checkbox"/>		10. DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) MARYLAND		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Louis Randall Hall		14. MOTHER'S MAIDEN NAME Anna Eliza Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. — INFORMANT Address Mrs. Ida Hall, Easton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH 24 h. Aspiration Pneumonia Subarachnoid Hemorrhage 24 h.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 1/30/60, 1960, and that death occurred at 12:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED R. Lane Whaley, M.D. St. Michaels, Md. 2-1-60	
ACTUAL SIGNATURE R. Lane Whaley, M.D.		PHYSICIAN'S NAME (Type) R. Lane Whaley - St. Michaels, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Feb 2, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Cemetery		22d. LOCATION (City, town, or county) Easton, R.F.D. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lane		24a. REC'D BY REGISTRAR ADDRESS DATE MAR 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1184 CERTIFICATE OF DEATH

Reg. Dist. No.

01185

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15 (4)
15M 9/55

Ross

88

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FASTON		c. LENGTH OF STAY IN 1b 2 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION memorial		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLOCK		
d. STREET ADDRESS TAYLORS AVE		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First BABY	Middle BOY	Last HENRY	
4. DATE OF DEATH	Month JANUARY	Day 13	Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JANUARY 10 1960	
9. AGE (In years last birthday) yrs. 8	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days 6	12. Hours 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWARD HENRY	14. MOTHER'S MAIDEN NAME LORRAINE ELIZABETH O'BRIEN	Address HURLOCK, MD		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT "MOTHER"	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Burmativity sub-dural hemorrhage	INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 12:15 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Edgar H. Schmidt	ADDRESS (Street, city or town, state) 3195 Washington St. 13th floor			DATE SIGNED Caesar 16 May 60
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 14, 1960	22c. NAME OF CEMETERY OR CREMATORIUM J.C.U.A.M. CEMETERY	22d. LOCATION (City, town, or county) PRESTON	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton & Son	ADDRESS Federalburg	24a. REC'D BY REGISTRAR DATE JAN 15 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Evans	
208017 IXVI				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG255 1-27-60 et

1185

CERTIFICATE OF DEATH

Reg. Dist. No.

01186

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>		d. STREET ADDRESS <i>Thompson St.</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (type or print) <i>Augusta</i>		First	Middle	Last	4. DATE OF DEATH <i>Jan 17 1960</i>	Month	Day	Year		
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 25, 1885</i>	9. AGE (In years lost birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Minutes	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>— — —</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Elijah Jewell</i>		14. MOTHER'S MAIDEN NAME <i>Lucy Thomas</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-18-4293A</i>		INFORMANT <i>Mildred M. Smith, St. Michaels, Md.</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i>		DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Diabetes Cereosclerosis		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>				
		DUE TO (c)		Diabetes Mellitus		3 years				
		DUE TO (c)		Hypertensive Cardiovascular Disease		10 yrs				
20a. MEDICAL CERTIFICATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Box 481, St. Michaels, Md.</i>	(County) <i>St. Michaels</i>	(State) <i>Md.</i>				
21. I certify that I attended the deceased from <i>15 Jan 1960</i> to <i>17 Jan 1960</i> that I last saw the deceased alive on <i>17 Jan 1960</i> , and that death occurred at <i>8 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Box 481, St. Michaels, Md.</i>		DATE SIGNED <i>1-20-60</i>				
ACTUAL SIGNATURE <i>R. Lane W. Roth, M.D.</i>										
PHYSICIAN'S NAME (Type) <i>R. Lane W. Roth, M.D.</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 20, 1960</i>	22c. NAME OF CEMETERY OR CEMATORIUM <i>Colored Cemetery</i>		22d. LOCATION (City, town, or county) <i>St. Michaels</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>St. Ambrose Stanion, St. Michaels</i>		ADDRESS <i>St. Ambrose Stanion, St. Michaels</i>	24a. REC'D BY REGISTRAR <i>JAN 20 '60</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. S. Krause</i>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01187

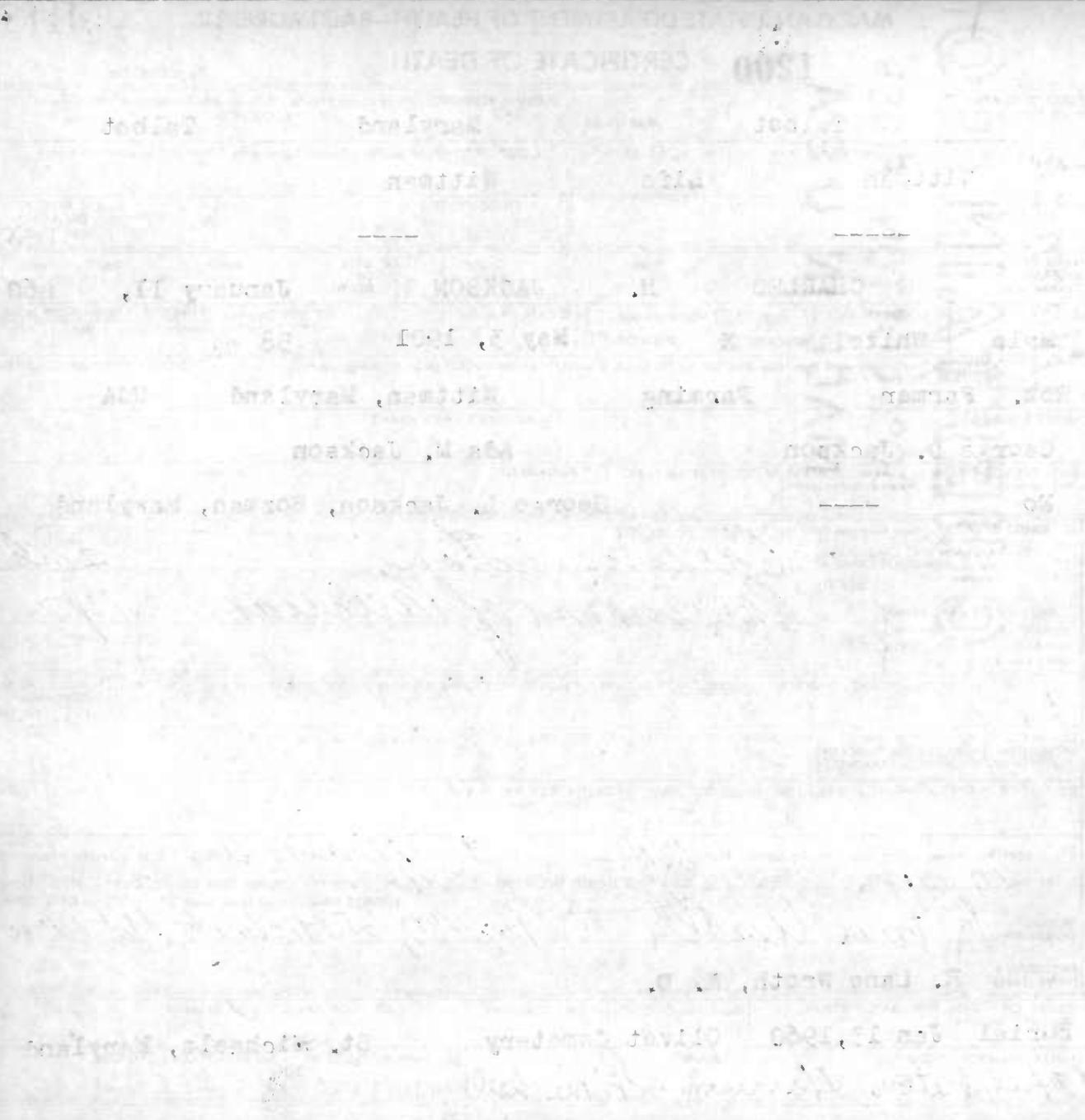
1200

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman		c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wittman		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CHARLES H. JACKSON		4. DATE OF DEATH January 11, 1960	Month Day Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1901	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kct. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Wittman, Maryland	
13. FATHER'S NAME George D. Jackson		14. MOTHER'S MAIDEN NAME Ada M. Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 000-00-0000	INFORMANT George L. Jackson, Bozman, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks. <i>Carcinomatosis</i> <i>Carcinoma of Pancreas</i> 147.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Box 487, St. Michaels, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 15 Dec. , 19 59 , to 11 January 1960 , that I last saw the deceased alive on 10 Jan. , 19 60 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D.		DATE SIGNED 1/11/60
ACTUAL SIGNATURE <i>R. Lane Wroth</i>				
PHYSICIAN'S NAME (Type) R. Lane Wroth, M. D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 13, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Olivet Cemetery	22d. LOCATION (City, town, or county) (State) St. Michaels, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>St. Michaels Harrison, St. Michaels</i>		ADDRESS ma	24a. REC'D BY REGISTRAR JAN 14 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1186 CERTIFICATE OF DEATH

Reg. Dist. No. 01188

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Talbot</i>				a. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>11 days - 9 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Easton</i>				<i>Hurlock</i> 09X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
<i>Memorial Hospital</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Laura</i>	Middle <i>Eleanor</i>	Last <i>Kenworthy</i>	4. DATE OF DEATH <i>January 30 1960</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>July 24, 1904</i>	C. AGE (In years last birthday) <i>55</i> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Operator of Laura E. Beauty Shop</i>		11. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pa.</i>	
13. FATHER'S NAME <i>Wayne D. Mower</i>		14. MOTHER'S MAIDEN NAME <i>Eva M. Shupe</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Unknown</i>		INFORMANT <i>Esther E. Mower, Barrington, New Jersey</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		<i>Acute myocardial infarction</i> 12 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i>		Unknown			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>202 Dover St.</i> (County) <i>Camden</i> (State) <i>New Jersey</i>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on <i>4:50 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Easton, Md.</i> DATE SIGNED <i>2-1-60</i>			
ACTUAL SIGNATURE <i>Robert W. Trever</i>		M.D.			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 2, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Harleigh Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Camden, New Jersey</i> (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Trampton & Son, Federalsburg, Maryland</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>FEB 5 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HANDBOOK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1187 CERTIFICATE OF DEATH

Reg. Dist. No. 01183

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boston</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1147 N. Harrison St.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels Road, Rural Boston</i>	
3. NAME OF DECEASED (Type or print) <i>Jerome</i>		First <i>Jerome</i>	Middle <i>Braeant</i>
		Last <i>Fuster</i>	4. DATE OF DEATH <i>January 2 1960</i>
S. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>March 1873</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. AGE (In years, months, days) <i>86 yrs.</i>	
13. FATHER'S NAME <i>Jerome H. Fuster</i>		14. MOTHER'S MAIDEN NAME <i>Martha M. Fuster</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>700-00-0000</i>	
17. INFORMANT <i>Mrs. J. B. Fuster</i>		Address <i>Rural Boston, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>334X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Stroke</i>		DUE TO <i>Arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anemias</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Amputated</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton</i>		20f. (City or town) (County) (State) <i>Easton</i>	
21. I certify that I attended the deceased from <i>1956</i> , to <i>1-2-1960</i> , that I last saw the deceased alive on <i>1-1-1960</i> , and that death occurred at <i>14 M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Easton, Md</i>			
ACTUAL SIGNATURE <i>P. E. Cox</i>		DATE SIGNED <i>1960</i>	
PHYSICIAN'S NAME (Type) <i>P. E. Cox</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 4, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield</i>		22d. LOCATION (City, town, or county) <i>Easton</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth Gask</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 6 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

87. ЗНОМНЯВ НІДАНИ ПО ТИГУНІВСЬКІЙ ОДАЧІ ВІДАЧІ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1188 CERTIFICATE OF DEATH

Reg. Dist. No. 011190

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>7 days - 8 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>The Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Casper</i>		d. STREET ADDRESS <i>1004 Market Street</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>October 31, 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Mr. Aquilla F. Meeks</i>		14. MOTHER'S MAIDEN NAME <i>Mary Cokman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Wife. John Barwick Denton, Md.</i>	
17. INFORMANT <i>Wife. John Barwick Denton, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>332x</i> (b) <i>Cerebral arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Choleodocholithiasis. Arteriosclerotic heart disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>11</i>		20f. (City or town) <i>Denton</i> (County) <i>Caroline</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>19</i> to <i>19</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>2:05 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert W. Trevor</i>		ADDRESS (Street, city or town, state) <i>Denton, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Robert Trevor</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 17, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Denton Greenbriar</i>		22d. LOCATION (City, town, or county) <i>Greenbriar</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeVingel Moore & Son Denton Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 19 '60</i>	
ADDRESS <i>DeVingel Moore & Son Denton Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	

TO HOSPITAL may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF MIGRATION-BALTIMORE, MD

198 CERTIFICATE OF DEATH

NAME

DECEASED PERSON

DEATH DATE

DEATH PLACE

DEATH CAUSE

DEATH CERTIFIED BY

DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01191

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		1201 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i> rural St. Michaels</i>		c. LENGTH OF STAY IN lb <i>30da</i>		b. COUNTY <i>Talbot</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Michaels Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>		d. STREET ADDRESS <i>Davis Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Leibin</i>		First <i>Leibin</i>	Middle <i>M.</i>	Last <i>Preston</i>	4. DATE OF DEATH <i>Jan 17 1960</i>
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 18 1887</i>	9. AGE (In years last birthday) yrs. <i>73</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>M. A. G.</i>					
13. FATHER'S NAME <i>Scott Gibbs</i>		14. MOTHER'S MAIDEN NAME <i>Sally Montgomery</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <i>153.8</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs. Anna Lee Preston Whitehead</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>cochlea severe progressive</i>		(b) <i>adenocarcinoma colon = widespread</i>		3 mos	
DUE TO (c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>abdominal, liver metastatic ch.</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Easton</i>	
21. I certify that I attended the deceased from <i>12-4-1959</i> to <i>1-17-1960</i> , that I last saw the deceased alive on <i>1-17-1960</i> , and that death occurred at <i>8:25 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Guy M. Reeser Jr.</i>				ADDRESS (Street, city or town, state) <i>St. Michaels, MD</i>	
PHYSICIAN'S NAME (Type) <i>Guy M. Reeser Jr.</i>		M.D.		DATE SIGNED <i>1-18-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation Jan 19 60</i>		22b. DATE THEREOF <i>Jan 19 60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Easton Jr.</i>		ADDRESS <i>Robert Easton Jr.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 20 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 X
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01192

FOR STATE
HEALTH DEPT.

M

Reg. Dist. No.

1189

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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17

2

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <i>Jalbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Queen Anne's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>22 hours-15 min. (Kent Narrows) Grasonville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital-Easton, Md.</i>		d. STREET ADDRESS <i>—</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17X-2	
3. NAME OF DECEASED (Type or print) <i>Robert Mole</i>		First <i>Robert</i>	Middle <i></i>
4. DATE OF DEATH <i>January 24 1960</i>		5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>1921</i>	9. AGE (In years birthday) <i>37 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fishing</i>	11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>
13. FATHER'S NAME <i>David Royster</i>		14. MOTHER'S MAIDEN NAME <i>Emmons</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>David Royster N.C. Rout 1, Milton</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <input checked="" type="checkbox"/> (1) <i>3rd Degree Burns of Face, Head, Back 23 hrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>916.0</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		DUE TO (b) <i>Arms</i>	
		DUE TO (c) <i>Smoke inhalation</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Asleep in shanty which caught fire.</i>	
20c. TIME OF INJURY 2:42 hour o. m. <i>1/23 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>At Kent Narrows</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Grasonville</i>
20f. (City or town) <i>Grasonville</i>		(County) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Dr. Irvin G. Hoyt</i>		DATE SIGNED <i>1/24/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/29/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Milton N.C.</i>
22d. LOCATION (City, town, or county) <i>Milton N.C.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Halsted 918 Ph. J Hill Are</i>		24a. REC'D BY REGISTRAR DATE JAN 27 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1190

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03798

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2		3		4		5							
FOR STATE HEALTH DEPT.		X		I		2		2							
<p><input checked="" type="checkbox"/> M</p>		<p><input type="checkbox"/> X</p>		<p><input type="checkbox"/> I</p>		<p><input type="checkbox"/> 2</p>		<p><input type="checkbox"/> 2</p>							
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX							
a. COUNTY Talbot		a. STATE Md		First Wayne		Month Jan		b. COUNTY Talbot							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton		Middle Benjamin		Day 11		c. LENGTH OF STAY IN 1b Life							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton High School		d. STREET ADDRESS 212 Prospect Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH		9. AGE (In years last birthday) 17 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) High School student		10b. KIND OF BUSINESS OR INDUSTRY School Boy		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Benjamin Russ		14. MOTHER'S MAIDEN NAME Alma Rimmer													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ukn.		17. INFORMANT J. Benjamin Russ, Easton, Maryland		212 Prospect Ave. address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 780.4		DUE TO		Vago-vagal spasm											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO													
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died suddenly in gym class													
20c. TIME OF INJURY Month, Day, Year Hour o. m. C 113 P.M. 1-11 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) School		20f. (City or town) EASTON Tal		(County) Md		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED 1-12-60			
ACTUAL SIGNATURE <i>Lewis Shultz</i>		EXAMINER'S NAME (Type) KELTY		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/60		22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Cemetery		22d. LOCATION (City, town, or county) Easton, Maryland									
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Frampton Carroll</i>		ADDRESS Easton, Maryland		24a. REC'D BY REGISTRAR DAT MAR 22 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>									

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01193

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. PLACE OF DEATH
o. COUNTY

TALBOT

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EASTON 26 days

c. LENGTH OF STAY IN 1b
RURAL and give nearest town)

EASTON

26 days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

EASTON Memorial Hosp.

3. NAME OF
DECEASED
(Type or print)First
MR OscarMiddle
C.Last
Schells

5. SEX

Male

6. COLOR OR RACE
white7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

Oct 3 1883

9. AGE (In years
lost birthday)
76 yrs.10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY
Hardware Store11. BIRTHPLACE (State or foreign country)
Marlitt Md12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William Schells.

14. MOTHER'S MAIDEN NAME

Emily Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

—

16. SOCIAL SECURITY NO.

213-01-8441

INFORMANT

Mrs Katie Schells. Address
EASTON Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Myocardial Infarction, Instantaneous

INTERVAL BETWEEN
ONSET AND DEATH

260 X

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

Arteriosclerotic Heart Disease

Instant

(b)

DUE TO

Diabetes Mellitus

yes

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Supracondylar Amputation left, for diabetic gangrene, foot

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item (B.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from

19

to

740

AM

, that I last saw the deceased

alive on 19, and that death occurred at

ADDRESS (Street, city or town, state)

ACTUAL
SIGNATURE

EASTON, Md 1/28/60

DATE SIGNED

PHYSICIAN'S
NAME (Type)

SHEPARD KRECH JR

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Burial

1-30-60

22c. NAME OF CEMETERY OR CREMATORI

Spangler Cemetery

22d. LOCATION (City, town, or county)

EASTON

(State)

Md

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

S. Hamilton Garrison, St. Michaels, Md

24d. REC'D BY REGISTRAR

DATE FEB 1 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03799

1202 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Cordova		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural - Cordova				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD		d. STREET ADDRESS RFD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Henry		First	Middle	Lost	4. DATE OF DEATH January	Month	Day	Year 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1903	9. AGE (In years last birthday) 56	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Milk		11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Chris Schlotzhauer		14. MOTHER'S MAIDEN NAME Bertha Plugge						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT 214-36-5338 Clara Neal Schlotzhauer, rural Cordova		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 11 m. 0 s.				
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Rheumatic heart disease with mitral stenosis and insufficiency		50 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>March 7</u> , 19 <u>59</u> to <u>Mar. 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar. 25</u> , 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Kurt L. Lederer</u> M.D.						ADDRESS (Street, city or town, state)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/60		22c. NAME OF CEMETERY OR CREMATORIAL St. Paul Church Cemt.		22d. LOCATION (City, town, or county) Cordova, RD, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll		ADDRESS Benton, Md.		24a. REC'D BY REGISTRAR DATE MAR 22 '60		24b. REGISTRAR'S SIGNATURE John S. Knoll		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1192 CERTIFICATE OF DEATH

Reg. Dist. No.

01194

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Queen Anne</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville, Md. 17x-2</u>		d. STREET ADDRESS <u>419 So. Commerce St</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>William</u>		First	Middle	Last	4. DATE OF DEATH <u>January 3 1960</u>	Month	Day	Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1896</u>	9. AGE (In years lost birthday) <u>63 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>William Edward Scott</u>		14. MOTHER'S MAIDEN NAME <u>Matheline Myers</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>220-32-2413</u>		17. INFORMANT <u>Lilie Scott, wife</u>		Address <u>Centreville Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u>		DUE TO <u>CERERAL HEMORRHAGE and</u>		EDEMA		INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>HYPERTENSION</u>		DUE TO (c)				YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Centreville</u>		(County) <u>Queen Anne</u>
21. I certify that I attended the deceased from <u>1/3/1960</u> to <u>1/3/1960</u> , that I last saw the deceased alive on <u>1/3/1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <u>105 Chesterfield Ave.</u>		DATE SIGNED <u>1/4/60</u>
ACTUAL SIGNATURE <u>J. Kent Young</u>		M.D.						
PHYSICIAN'S NAME (Type) <u>J KENT YOUNG</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/60</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Centreville (col) Cem.</u>		22d. LOCATION (City, town, or county) <u>Centreville, Md.</u>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walker, Chesterfield, Md.</u>		ADDRESS <u>u Valley</u>		24a. REC'D BY REGISTRAR <u>JAN 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Walker</u>		

12:06 A.M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8.9 FilmG25 3-24-60 at

1193 CERTIFICATE OF DEATH

Reg. Dist. No.

01195

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		
Talbot MARYLAND		Maryland Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Easton	1 1/2 hr	Newcomb		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
Memorial Hospital	X			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
Mr. Edgar PARKER	Small		January 3	
4. DATE OF DEATH	Month	Day	Year	
1909	January	3	1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
Male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	October 23, 1886	
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
70 yrs.	Months	Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Advertising	Retired	New York	United States	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
George Washington Small	Julia B. Pecky			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
Unknown	06-09-44W	Son	United States Army	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial infarction 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	6 hrs			
(b)	atherosclerotic occlusive			
DUE TO				
(c)	coronary heart d.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)
Hour a. m. p. m.	19	While at work <input type="checkbox"/> at work <input type="checkbox"/>		(County) (State)
21. I certify that I attended the deceased from	1-2-	1960	to	1-3-1960
alive on	1-3-	1960	and that death occurred at	2:27 M, from the causes and on the date stated above.
ACTUAL SIGNATURE	Dr. Guy Reeser, Jr.			ADDRESS (Street, city or town, state)
PHYSICIAN'S NAME (Type)	Dr. Guy Reeser, Jr.			DATE SIGNED
22a. BURIAL/CREMATION REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)
Funeral	Jan 5, 59	Fort Smallwood	Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
Reed	Edison Md	JAN 6 '60	Arthur S. Hause	

TO HOSPITAL
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2709

CERTIFICATE OF DEATH

15005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>21 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 EASTON</i>		d. STREET ADDRESS <i>312 OAK ST.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>John</i>		First <i>H.</i>	Middle <i>S.</i>	Last <i>Judy</i>	4. DATE OF DEATH <i>January 7</i>	Month <i>January</i>	Day <i>7</i>	Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 11, 1880</i>		9. AGE (In years lost birthday) <i>79</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Artist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PAINTING</i>		11. BIRTHPLACE (State or foreign country) <i>HUNGRY</i>		12. CITIZEN OF WHAT COUNTRY? <i>S. WASHINGTON ST. EASTON, MD.</i>					
13. FATHER'S NAME <i>UNAVAILABLE</i>		14. MOTHER'S MAIDEN NAME <i>SUZAN PONYATOVSKY</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Mrs. J. F. FREELAND</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Cerebral Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>acute</i>	
						 (b) <i>Cerebral Atherosclerosis</i>				—	
						(c) <i>Diabetes Mellitus</i>				4-5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Atherosclerosis; Diabetic Acidosis</i>						20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1/6, 1960, to 117, 1960, that I last saw the deceased alive on 117, 1960, and that death occurred at 6:10 AM, from the causes and on the date stated above.</i>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>12 N. HANSON ST</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>		(State) <i>MD</i>	
21. I certify that I attended the deceased from 1/6, 1960, to 117, 1960, that I last saw the deceased alive on 117, 1960, and that death occurred at 6:10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>12 N. HANSON ST</i> DATE SIGNED <i>1/6/60</i>											
ACTUAL SIGNATURE <i>L. J. E. Giseader</i>		M.D.									
PHYSICIAN'S NAME (Type) <i>L. J. E. Giseader</i>		ADDRESS <i>12 N. HANSON ST</i>		EASTON, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/1/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>OAK LAWN (EMT.)</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>MD</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Hampton Caudell</i>		ADDRESS <i>EASTON, MD</i>		24a. REC'D BY REGISTRAR <i>APR 19 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					
VS A15 (4) 15M 9/55											

260x

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,13 FilmG255 2-8-60 et

1194

CERTIFICATE OF DEATH

Reg. Dist. No.

01196

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>05 x-2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edwin H. E. Thieroff</u>		4. DATE OF DEATH <u>January 29 1960</u>	Month Day Year
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16 1884</u>
9. AGE (In years last birthday) <u>75 yrs.</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	12. BIRTHPLACE (State or foreign country) <u>Ohio</u>
13. FATHER'S NAME <u>John J. Thieroff</u>	14. MOTHER'S MAIDEN NAME <u>Anna M Greenler</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>220-16-7522</u>	INFORMANT <u>Henreitta Milleman</u>	Address <u>Preston</u>
17. INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Quacation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <u>157X</u> (b) DUE TO <u>Cancer (carcinos) head of pancreas.</u> (c) DUE TO <u>Dec 59?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Easton, Md.</u>	(County) <u>Caroline Co.</u>	(State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>60</u> , to <u>1/29</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1/28</u> , 19 <u>60</u> , and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. T. B. Ambler</u>	M.D. <u>J. T. B. AMBLER</u>	ADDRESS (Street, city or town, state) <u>Easton, Md.</u>	DATE SIGNED <u>1/30/60</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/31/60</u>	22c. NAME OF CEMETERY OR CREMATORIY <u>Jr. O. U. A. M.</u>	22d. LOCATION (City, town, or county) (State) <u>Preston, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Hollis</u>	ADDRESS <u>Preston, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>FEB 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Henry S. Hanna</u>

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE GOVERNMENT OF GUYANA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01197

1195

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ridgely</i>		d. STREET ADDRESS <i>05 x 2</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hosp</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>John</i>		First	Middle	Lost	4. DATE OF DEATH <i>WALKER</i>	Month <i>JAN</i>	Day <i>3</i>	Year <i>1960</i>							
S. SEX <i>m</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JANUARY 8, 1867</i>	9. AGE (In years last birthday) <i>25</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARMER</i>		11. BIRTHPLACE (Side of foreign country) <i>Dei</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>									
13. FATHER'S NAME <i>Joseph Young</i>		14. MOTHER'S MAIDEN NAME <i>Adelia WALKER</i>		Address <i>Rosa Walker Ridgely, Md.</i>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>213-22-8492</i>		17. INFORMANT <i>Rosa Walker</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>				
						<i>Bronchitis-Pneumonia (Arteriosclerotic heart disease) Generalized Arteriosclerosis Diabetes mellitus.</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Nephrosclerosis</i>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>See above</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Ridgely, Maryland</i>		20f. (City or town) <i>Ridgely</i>	(County) <i>Caroline</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Dec 25</i> , 1959, to <i>Dec 30</i> , 1959, that I last saw the deceased alive on <i>Dec 30</i> , 1959, and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <i>Ridgely, Maryland</i>					DATE SIGNED <i>1/7/60</i>			
ACTUAL SIGNATURE <i>Charles H. Winacott</i>		M.D.													
PHYSICIAN'S NAME (Type) <i>CHARLES H. WINACOTT</i>							(Seen Dec 30, 1959, by Dr. Charles H. Winacott, M.D.)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-6-60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Denton Cemetery</i>		22d. LOCATION (City, town, or county) <i>Denton, Maryland</i>		(State) <i>Maryland</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>James A. Darwell</i>		ADDRESS <i>Easton, Md.</i>		24a. REC'D BY REGISTRAR <i>DECEMBER 11 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>									

TO HOSPITAL
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01198

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		1196		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>16days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Memorial Hospital</i>				d. STREET ADDRESS <i>09x-2</i>	
3. NAME OF DECEASED (Type or print) <i>Elmer</i>		First <i>Elmer</i>	Middle <i>John</i>	Last <i>Windsor</i>	4. DATE OF DEATH <i>January 7 1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 25 1895</i>	9. AGE (In years last birthday) <i>64 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Bus Driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dorchester Co.</i>		10c. BIRTHPLACE (State or foreign country) <i>Dorchester County, Maryland</i>	
13. FATHER'S NAME <i>John E. Windsor</i>		14. MOTHER'S MAIDEN NAME <i>Blanche Harper</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>199-03-9551</i>		17. INFORMANT <i>Miss Amy V. Windsor, Hurlock, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>603X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost. <i>(b) Gouty urophathy</i> <i>(c) Coronary atherosclerotic heart disease</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/23/1959</i> to <i>1/7/1960</i> , that I last saw the deceased alive on <i>1/7/1960</i> , and that death occurred at <i>6:25 AM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Harrison Thurston</i>		M.D.		ADDRESS (Street, city or town, state) <i>Hanson Street, Easton, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Thurston, Harrison</i>		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 9, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington Cemetery</i>		22d. LOCATION (City, town, or county) <i>Hurlock, Maryland</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.J. Frampton & Son</i>		ADDRESS <i>FEDERALSBURG</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 12 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

CERTIFICATE OF DEATH

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NAME

STAN
ET
AL

TOM

JOHN
EDWARD
LAWRENCE

NAME OF DECEASED

JOHN EDWARD LAWRENCE
TOM STANLEY

STANLEY, JOHN EDWARD

TOM STANLEY

LAWRENCE, JOHN EDWARD

TOM STANLEY

LAWRENCE, JOHN EDWARD

TOM STANLEY

LAWRENCE, JOHN EDWARD

TOM STANLEY

MATERIAL PREPARED BY: JOHN EDWARD LAWRENCE

MATERIAL

SAFETY INSPECTOR

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